

CONTRA COSTA COUNTY: DATA NOTEBOOK 2015

FOR CALIFORNIA

MENTAL HEALTH BOARDS AND COMMISSIONS



*Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Mental Health Boards/Commissions*

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FOR CALIFORNIA

MENTAL HEALTH BOARDS AND COMMISSIONS

County Population (2014): 1,096,637

Website for County Department of Mental Health (MH) or Behavioral Health:

www.cchealth.org

Website for Local County MH Data and Reports:

www.cchealth.org

Website for local MH Board/Commission Meeting Announcements and Reports:

www.cchealth.org/mentalhealth/mhc/

Specialty MH Data¹ from 2013: see Archives folder at <http://www.calegro.com/>

Total number of persons receiving Medi-Cal in your county (2013): 200,963

Average number Medi-Cal eligible persons per month: 164,128

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 47.3 %

Adults, 18 and over: 52.7 %

Total persons with SMI² or SED³ who received Specialty MH services (2013): 13,170

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 38.2 %

Adults, 18 and over: 61.8 %

¹ Downloaded July 2014 from the former APS Healthcare website, www.caeqro.com.

² Serious Mental Illness, term used for adults 18 and older.

³ Severe Emotional Disorder, term used for children 17 and under.

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Introduction: Purpose, Mandates, and Data Resources

What is the “Data Notebook?”

It is a structured format for reviewing information and reporting on the mental health services in each county. For some questions, the Data Notebook supplies data for each county from public resources (e.g., mental health (MH) data from the External Quality Review Organization⁴ and substance use disorders treatment reports). For other questions, we request that local mental health boards obtain information from their county behavioral health department because there is no public source.

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates⁵ to review the local county mental health services and report on performance every year
- function as an educational resource about mental health data for local boards
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate⁶ to review and report on the public mental health system in our state.

Every year, the mental health boards and commissions are required to review data about the services for mental health in their county. The local boards are required to report their findings to the CMHPC every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information. The Data Notebook is organized to provide data and solicit responses from the mental health board regarding specific topics so that the information can be readily analyzed and reported by the CMHPC each year. These data are compiled in a report to inform policy makers, stakeholders and the general public.

The CMHPC serves under the umbrella of the Department of Health Care Services (DHCS) and must fulfill certain legal mandates to report on the public mental health system every year. We analyzed all Data Notebooks received in 2014 from the mental health boards and commissions; information which represented 41 counties that comprised a geographic area containing 83% of this state’s population.⁷ Our analyses produced the Statewide Overview report that is on the CMHPC website at:

<http://www.dhcs.ca.gov/services/MH/Documents/CMHPCCSIDataNBReport2015.pdf>

⁴ See www.CALEQRO.com for county level data. Select the Archives folder containing reports for each county MH Plan, or check “New Reports” as available for the most recent year data.

⁵ W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

⁶ W.I.C. 5772 (c), requires annual reports from the California Mental Health Planning Council.

⁷ An additional six counties submitted their documents after our report was completed, for a total participation of 47 counties in partnership with their local advisory boards.

Other recent reports from various committees of the CMHPC can be found at:
<http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx>

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function.

Data Resources for the Data Notebook

Selected questions request input from members of the local boards. Your experience and perspectives are valuable, and that is one reason these boards exist. Most important, stakeholder input is taken into account by legislators and agency policy makers when they design and implement programs.

Some information is available from your local Department of Behavioral Health. Besides your county's Director of Behavioral Health or the staff for MH board liaison, other key contacts may include the Administrator for Alcohol and other Drug Programs, your Quality Improvement Coordinator or the MHSA Coordinator. For your questions about healthcare disparities and related outreach efforts, you may wish to contact the county's Cultural Competence Coordinator or the related committee.

Data about local specialty MH services may be found in reports from the external quality review organization (EQRO) (www.CALEQRO.com). Check the "Archives" file for "Reports." Select the most recent "EQRO MHP Report" for your county. For detailed numbers, see "Appendix D" in the report. For an estimate of the percent of clients with serious mental illness (SMI) who also have substance use disorders (SUD), consult the section titled "Information Systems Review."

Finally, we are very excited about a new data resource for your reports. We have arranged with DHCS to obtain substance use disorders treatment data to share with you. These data are made available for publication by the CalOMS-Tx⁸ group at the Office of Applied Research and Analysis after review by the office charged with protecting patient privacy and HIPAA compliance.

We have customized each report by placing the data for your county within the substance use disorders section, followed by discussion questions on this topic. We also provide statewide reference data so that you can compare it to the information for your own community.

⁸ CalOMS-Tx herein refers to both the "outcomes management system" for data about substance use treatment (Tx), and to the DHCS unit that performs the data collection, analyses, and reporting.

Instructions for Completing the Data Notebook 2015

Most county Departments of Mental Health are now Departments of Behavioral Health. Many local advisory boards have re-named themselves in terms of behavioral health, not just mental health boards or commissions. Some define their mission in more specific terms, as “Mental Health and Drug and Alcohol Boards.” However, not all groups are ready to make such changes at this time.

Additionally, in terms of resources, some counties have inpatient facilities and/or crisis response teams to meet the needs of individuals experiencing a mental health crisis. Some counties have just one such resource available and some counties have none.

In respect of all these differences, we are presenting topics covering two critical issues for review by the local advisory boards in this year’s Data Notebook. Please review the data we provide within the report. Of course, you are welcome to consult other resources for further background if you so choose.

Please discuss and answer the questions for these topics:

- A. Strategies to Meet the Needs of Persons Experiencing Mental Health Crises: Treatment Options and Alternatives to Locked (Involuntary) Facilities
- B. Integrated Care: Treating Individuals with both MH and SU Disorders

Please submit your completed Data Notebook report to the CMHPC at:

DataNotebook@CMHPC.ca.gov

For more information, please call (916) 449-5249, or email the address above.

Thank you for participating in our project.

Strategies to Meet Needs of Persons Experiencing a Mental Health Crisis

Treatment Options and Alternatives to Locked (Involuntary) Facilities

While every effort is made to notify Californians of the availability of services and to encourage individuals to seek services early, sometimes a crisis occurs and immediate intervention is needed. In a worst case scenario, law enforcement is called to respond but in a better case scenario, a multi-disciplinary team that includes a mental health professional and a peer will meet with the individual in crisis. The toll and costs of hospitalizations and incarceration of individuals experiencing a mental health crisis are high on both the individual and public system. Many counties have implemented diversionary programs to help persons in crisis manage the situation, de-escalate their symptoms and recover without having to enter an institution.

We are seeking to identify the resources and options that are available to promote the least restrictive environment that will help individuals experiencing a MH crisis to stabilize and move toward recovery. Our goal is to highlight effective programs that meet this essential need on the continuum of services. Effective programs are an excellent way to reduce stigma, and to reduce costs allowing those savings to be used in other areas of the service system. By sharing information about programs with a substantial track record, we wish to promote programs of quality, excellence and safety.

Continuum of Care for SMI in your Community

1. Do you have these types of facilities in your county? Please check all that apply. Please mark 'Other' (and describe) if your county contracts for beds outside of your county.

- IMDs (Institutions for Mental Diseases, used often for placement of MH clients who are under conservatorship and others)
- PHFs (Psychiatric Health Facilities)
- SNF with PTP (Skilled Nursing Facility with Psychiatric Treatment Program)
- State Hospital beds
- Psychiatric hospital beds
- None of the above

Other, please describe We contract with other agencies to provide IMDs, PHFs, State Hospital beds for adults, Transitional Age Youth (TAY), and children.

2. If you do not have any of the above facilities in your county and you have a need that goes beyond crisis intervention, how do you handle a need for a longer term hospitalization (14-90 days)?

Crisis intervention services

Licensed adult residential facility (board and care home) that receive extra funding from the county (or placing agency) for additional MH-related services

Other, please describe. Treatment is contracted to for-profit and non-profit agencies or the State hospitals. Finding treatment for children is a major concern, children have resided in Psychiatric Emergency at the County Medical Facility in Martinez well beyond the recommended time limits.

3. What alternatives to a locked facility do you have for those experiencing an immediate MH crisis? Please check all that apply.

Crisis Stabilization Service (23 hours)—Psychiatric Emergency at CCRMC

Crisis Residential

Mobile Crisis Intervention Teams—Children contracted through Seneca

Transport to another county for treatment

Transport to another state for treatment

Assisted Outpatient Treatment (AOT) teams (Laura's Law type programs)

Licensed adult residential facility (board and care home) that receives extra funding from the county (or placing agency) for additional MH-related services

Other, please list or describe _____

4. Does your county have a MH court, jail diversion program, or similar mechanism to help individuals whose MH crisis or illness contributed to their involvement with the criminal justice system? Please check all that apply.

MH court

- Drug Court (some counties have combined into “problem-solving courts”)
- Jail diversion program (a court-ordered MH program where client avoids jail)
- Re-entry programs with MH/BH services to assist persons released into the community after leaving a correctional facility (e.g. programs funded by AB 109, Proposition 47, or related services)
- Other, please describe _____
- None of the above

5. Creative Solutions. Does your county have an innovative program or another way to address needs for inpatient care or emergency MH services, other than what has been listed above?

Yes No

If yes, please list and describe Miller Wellness Center (Assessment and Recovery Center)

6. Prevention. Does your county have any programs implemented specifically as alternatives to locked facilities that haven’t been addressed above? This is an open question that could include MHSA-funded prevention programs designed to assist individuals in crisis, or to prevent first-break psychosis. Such programs could include local implementation of a program for more MH triage workers (funded by SB 82). This question could also be addressed by other strategies that engage public (county) and private partnerships, regardless of funding sources.

Contra Costa’s First Hope program is a treatment program to prevent first break psychosis. It is certified as an evidence based practice by the Portland Identification and Early Referral (PIER) Training Institute.

7. Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

8. If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

These two questions were answered by members of the Mental Health Commission representing varying viewpoints.

FROM DIANA MAKIEVE—Member at Large

- 1) I know from anecdotal accounts about the bed shortage at Psychiatric Emergency and that people of all ages are turned away or have to wait days before a bed becomes available for treatment.
- 2) I understand that there are board and care and/or treatment facility issues in our county. It is particularly difficult for families of dependent children or even adult dependent children, when the care facility is out of the local area, and sometimes out of state.
- 3) I'm not sure how to frame this issue but I know it's a problem: Family members struggle to find the resources that exist to help them with a child experiencing their first psychic experience. It can be months before a parent figures out the system, accepts the seriousness of the problem, and finally gets to the place that can help them. I love our New Hope program and feel that this process may ultimately address most of this "gap" in service. But, I believe that New Hope focuses on pre schizophrenic behavior and because many of the young people that I get involved with are initially diagnosed or suspected to be bipolar, or depression with PTSD, or something that does not fit into the New Hope range, these young people are left out. The problem may be complicated by many other factors: Parent is in denial and is looking for a quick fix, people have private insurance that cover their young adults and/or children and work with their pediatrician/md and therapist, and there is so much stigma and scariness associated with severe mental illness that families are afraid/reluctant to ask.

What we need:

Expand New Hope to include treatment and support for all families with an age appropriate dependent child that presents mental health symptoms. I love the question process that takes place with the parent/guardian and child that works as a triage to determine if they qualify. The same triage process could work for all levels of MI, specific directed early treatment providing a supported/educational process to guide the family through recovery, regardless of the diagnosis

FROM SAM YOSHIOKA—Family Member/Older Adults

1) Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

A. The obvious unmet needs for children and transition-aged youth adults are inpatient residential beds.

B. We need a program of outreach toward older adults to identify those are who are in need of behavioral health services, especially older adults who are in residential care facilities.

2) If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

- A. Do away with the eligibility process before seeing those in need. Everyone's behavioral health needs should be seen first
- B. All health needs, which includes behavioral health needs, should be met without questions, first.
- C. Have program that follows after Emergency and Psych Emergency Care.

FROM GINA SWIRSDING—Consumer

West County Needs for Mental Health Patients

A) Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.

Children: 14 and under

1. In the whole county there are no Psychiatric hospital beds for children who are in a psychotic and suicidal crisis. When these children are placed on medications at PES, they need to be hospitalized (a minimum of two weeks) to be monitored how affective the medications are and if there are any side effects. It is dangerous and a medical neglect to release a child to their parents care who are introduced to new a psychiatric medications given to them at PES.
2. Many severe psychiatric children who have histories of violence are refused acceptance of hospitalization in hospitals out of county. As a result, many have their hospitalization in Psych Emergency Services (PES) department in Martinez. Some of these children are placed far away from family. Some of the teenagers are sent to Juvenile Hall for their hospitalization.
3. In Contra Costa County, we need a partial hospitalization program for teenagers (13-18 years of age). There are counties that have such programs because we don't have such a program; the programs in other counties have to take our patients, which are overcrowding these programs. Our patients in our county are placed on waiting list in these other counties.

Children, TAY and Adults who are newly diagnosed.

1. The closure of Doctors Hospital in San Pablo gives West County Behavior Health Patients no place to go when in a mental health crisis. Walk in Emergency Room. The Hospital is located in Central County, which isn't accessible easily by public transportation. The next available hospital is located in Alameda County, Berkeley, which has limited bed space for West County Patients. If patents go to Berkeley, many end up going to John George in Fremont, which is 45 minutes away minimally could be hours in traffic from West County. Many patients go there with no visits from family or friends due to the distance. After discharge, they are forced to take public transportation if family or friends can't come and pick them up.
2. The closure of the hospital doesn't help patients who have anxiety attacks who need immediate medical attention to relieve its symptoms. The ambulance drive distance is very costly on the health care system and the patient.
- 3 Adults/Children need to be diagnosed properly and this can't be done by a 4-hour visit at PES and a once a month visit with a psychiatrist. For both Children and Adults in our county patients can't see a psychiatrist or therapist once a week so as a result these patients aren't diagnosed properly. There is a need for more psychiatrist and psychologist who can treat

psychiatric patients so they can be seen once a week, especially for patients who are recovering from a major psychiatric crisis.

4. As with the children, we don't have enough Partial Hospitalization programs for Adults who recovering from a crisis and a hospitalization and still need to be cared for. It is such day programs that help stabilize the patient and adjust medications dosages as needed. This also helps the patient deal with a new psychiatric diagnosis and gradually help them return to normal daily living.

5. In West County, it is hard to find a psychiatrist in this area. Most of the psychiatrists work in Central County and Berkeley. Patients are forced to take several different means of public transportation to see a therapist/psychiatrist for an appointment. When in a crisis, it's hard for patients to seek help for themselves that results in more visits to PES in Martinez or arrest and placed in criminal custody.

6. The majority of the population in both Juvenile Hall and Contra Costa Jail come from West County this includes the Behavior Health Patients. Many of the prisoners who are mentally ill refuse to accept treatment for their mental illness while incarcerated. The criminal Justice system here in California has become the place to send our mentally ill patients for treatment. Law enforcement officers have the belief that while these patients are sent to jail or prison they will get the proper mental health services they need which isn't the case. The mentally ill that are incarcerated will be lucky if they see a therapist or psychiatrist once a month. Prison and Jails are for criminals and not the mentally ill patient. Many are placed there for repeated minor offenses that are exaggerated as felonies because law enforcement officers want them off the streets because they are a bother to society.

7. Most of our homeless population in West County suffers from mental health diagnosis. Many of them are sent to Jail and then released. The jail system is a revolving door to them. After discharge from jail they are the same mentally with no tools like DPT, CBT treatment, housing and other means to stabilize their mental health needs and homeless situation. Many of our mentally ill homeless patients are victims of violence due to living on the streets. A lot of the women are raped and beaten and taken advantage of due to living on the streets.

B.) If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

1. A Hospital in our county that takes in Children in Mental Health crisis so our children don't have to be sent out of county. A hospital policy that takes in all patients with no refusal of services to certain patients.
2. Partial Hospitalization Program for Teenagers. For teenagers who newly diagnosed with a mental illness, teens exiting hospitalization can have further treatment and care to stabilize them and to gradually bring them back to their normal daily living of school and home life. A program that takes in all patients with no policy of refusal of services to some patients
3. Partial Hospitalization Program for Adults as mentioned above. A program that takes in all patients with no policy of refusal of services to some patients.

LAUREN RETTAGLIATA, Chair-- Mental Health Commission

The above responses give you a sense of what the Mental Health Commission as citizen advocates sees as the top unmet needs.

There are services for crisis through Psych Emergency (PES), and the Inpatient Ward at Contra Costa Regional Medical Center (CCRMC), but space is very limited and patients are discharged way too quickly. There are services in the community for those with a serious mental illness such as full service partnerships, but for many with a serious mental illness that need a stabilized inpatient stay beyond 14 days or highly structured partial hospitalization (patient goes home to sleep)-- there are not programs in county.

Housing for the seriously mentally ill is the number one service identified by consumers and family members as most needed. Board & Care facilities now used do not meet the needs of those who are homeless either in quantity or more importantly treatment needs.

Our jails both in Martinez and West County have no mental health programs besides medication and assessment. Inmates in M module in the Martinez Facility for the seriously mental ill are locked in solitary confinement for 23 hours a day. West County has AA & NA programs but no treatment programs for the seriously mentally ill though there may be designated hours for Mental Health Staff to see inmates in a small office with little or no confidential needs.

We have no children inpatient Psychiatric beds in our county, and there have been woefully long stays even months that children have resided in PES.

There needs to be a working relationship established between Behavioral Health Administration and the Regional Center to care for both adults and children who are dually diagnosed—so that the best programs and funding can be utilized for care.

Integrated Care: Treating Individuals with both MH and SU Disorders⁹

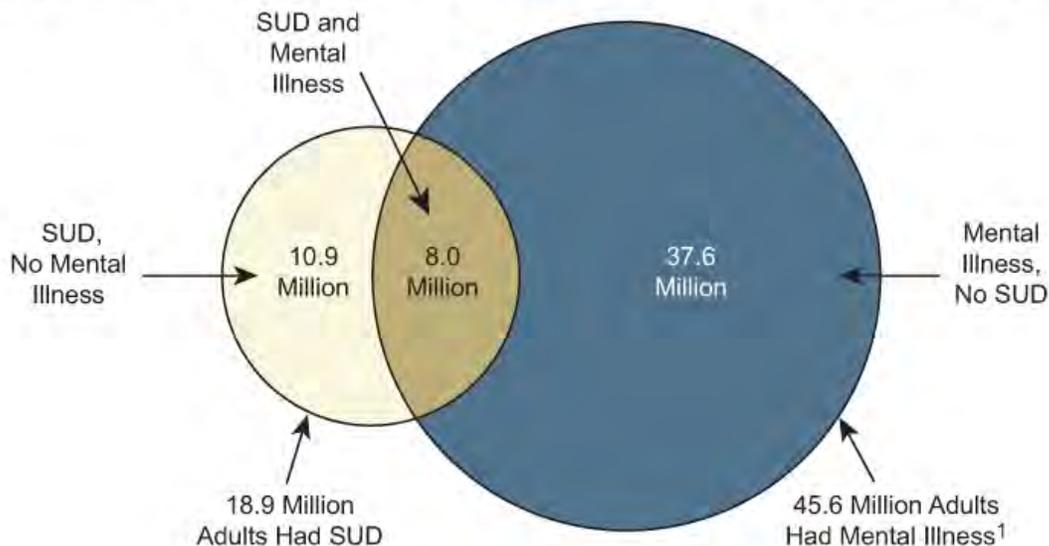
Understanding the Scope of the Problem using National Statistics

We show examples of national data from the NSDUH¹⁰ survey to give perspective on the data for our local communities and state. Many experts believe these data are an under-estimate of the true scope of the problem. All figures in this introduction are from this NSDUH survey report. We ask: how many people are affected by these disorders?

The report describes adults who had any mental illness, or a substance use disorder, or both problems in 2011, the most recent year for which there is national data.

- A total of 45.6 million adults had a mental illness. Of that group, 8 million (17.6 percent of total) also had a substance use disorder.
- Among the 18.9 million adults with substance use disorder, 8.0 million (42.3 percent) also had a mental illness.

Past Year Substance Dependence or Abuse and Mental Illness among Adults Aged 18 or Older: 2011



The problem is even more serious as we consider the risks for those with severe mental illness (SMI), a subset of those with “any” MH disorder shown above.

⁹ SU = substance use. SUD= Substance use disorders, referring to problems with abusing drugs, alcohol, or both. Drugs refer to both illegal substances and prescription drugs used for purposes other than those legally prescribed or intended. See www.drugabuse.gov for more information.

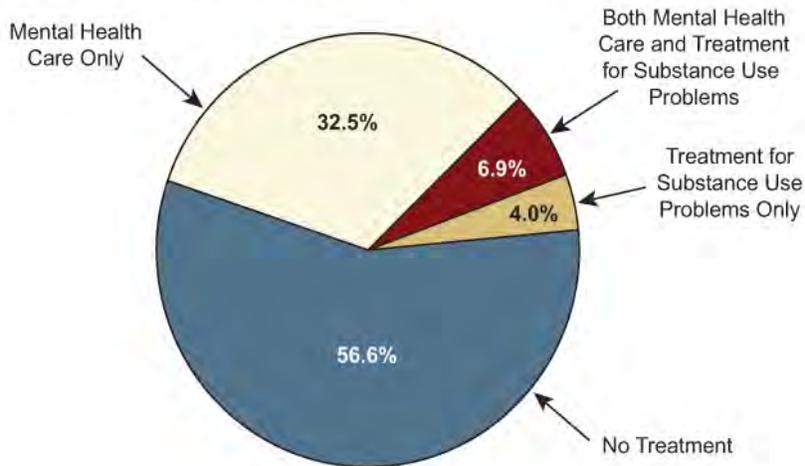
¹⁰ NSDUH: The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and abuse and mental disorders in the U.S. population. See more information at: http://archive.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhr2011.htm

Who received treatment, and what kind? In the co-occurring disorder population, we would expect better recovery outcomes for those who receive treatment for both disorders. However, such integrated treatment may be difficult to access.

For the 8.0 million adults with co-occurring disorders, how many received treatment in the last year for MH disorders, SUD, both, or neither? Data from the NSDUH show that:

- 43.4 percent received some kind of treatment for either SUD or mental illness during the past year, however:
 - 32.5 percent received MH care only,
 - 4.0 percent received SUD treatment only, and
 - just 6.9 percent received treatment for both disorders.
- But more than half -- 56.6 percent received no treatment at all for either disorder.

Figure 4.12 Past Year Mental Health Care and Treatment for Substance Use Problems among Adults Aged 18 or Older with Both Mental Illness and a Substance Use Disorder: 2011

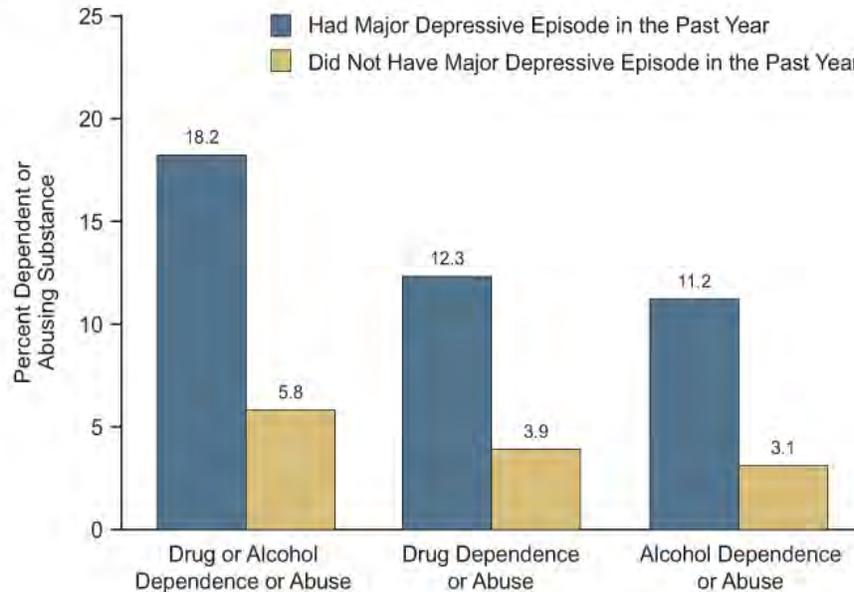


8.0 Million Adults with Co-Occurring
Mental Illness and Substance Use Disorder

Note: Mental health care is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Treatment for substance use problems refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Children and youth under 18 are also affected. Those who had a major depressive episode were three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who did not have depression. Such episodes may be an early indicator of risk for more severe emotional disorders.

Figure 4.15 Past Year Substance Dependence or Abuse among Youths Aged 12 to 17, by Major Depressive Episode in the Past Year: 2011



The NSDUH report also found that youth with a major depressive episode had an increased risk for use of any type of illicit drug. A related but very serious concern is the increased risk for abuse of prescription drugs (when taken for non-prescribed uses).

Data: Understanding who Receives SUD Treatment in your County

The next two pages will show some county-level information supplied by the data specialists of CalOMS-Tx in the Office of Applied Research and Analysis at DHCS. Before release to us, these data were reviewed by the DHCS offices charged with protecting patient privacy and HIPAA compliance. These data are from Fiscal Year 2013-2014.

Some data cells may not have any numbers, but instead are marked by an asterisk, “*” which means that the numbers have been redacted (hidden) to protect patient privacy because the total number is too small. Counties with small populations may see many such asterisks, with the result that only limited data can be seen for those counties.

Access: Who Receives Services? The first part will present data for the demographics of those admitted for SUD treatment and the type of services. Demographics include age, gender, major race/ethnicity groups, and county. Service types in this dataset are outpatient, detox, or residential.

What are the Client Outcomes? The second part contains data regarding client outcomes. Discharge outcomes after thirty days include:

- return to substance use
- arrests
- employment
- housing situation (homeless vs. stable housing of any type)
- social supports within the last 30 days (includes 12-step programs as well as general social support activities, more than 4 or fewer than 4).

You will see that there is a certain percentage of data assigned as “missing.” These are not redacted (hidden) numbers. “Missing data” indicates the numbers of clients for which no further data could be obtained by the treatment program. Some clients are no longer reachable by program staff or are otherwise lost to follow-up.

Finally, please examine the California State Data reference pages at the end of this document. We live in a highly diverse state and so your county data may or may not resemble the statewide data. However, these data are worth review and discussion as you consider advocacy and policies regarding demographic disparities in service access and unmet needs.

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

County: CONTRA COSTA

Service Type:

Outpatient	DETOX	Residential	Total
1687	227	907	2821
59.8%	8.05%	32.15%	100%

Age at Admission:

Under 18	18 - 25	26 - 35	36 and Older	Total
249	438	833	1301	2821
8.83%	15.53%	29.53%	46.12%	100%

Gender:

Male	Female	Total
1913	908	2821
67.81%	32.19%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
29	77	658	603	115	1339	2821
1.03%	2.73%	23.33%	21.38%	4.08%	47.47%	100%

CLIENT OUTCOMES: Key Indicators of Client Recovery for Prior 30 days at Discharge

Discharges in FY 2013-2014

County: CONTRA COSTA

Substance Use:

None	Use Data Missing	Use Documented	Total
837	191	283	1311
64%	15%	22%	100%

Arrests:

1 or more Arrests	Arrest Data Missing	No Arrests	Total
39	191	1081	1311
3%	15%	82%	100%

Employment:

Employed	Data Missing	None	Total
209	191	911	1311
16%	15%	69%	100%

Housing Situation

Homeless	Living Data Missing	Stable Housing	Total
53	191	1067	1311
4%	15%	81%	100%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Missing	Total
453	667	191	1311
35%	51%	15%	100%

The Impact of Substance Abuse on the MH System of Care in your County

9. This next question may help define the nature and scope of the substance use problem in your community. Resources for such information may include the Alcohol and Other Drug Administrator for your county, your county Sheriff's Department, or the Behavioral Health Director.

What substances are the most commonly abused in your county? Please select the top three drug categories below (and indicate estimated percentage if known).

***** Based on FY13-14 Treatment System Admission Data**

19.9% Alcohol

15.1 Marijuana, hashish or synthetic marijuana-like drugs (e.g. 'spice,'bath salts')

31.1% Amphetamines, methamphetamine, prescription stimulants (ADHD drugs)

6.0% Cocaine, 'crack' cocaine

9.1% Opioids (heroin, opium, prescription opioid pain relievers)

Club Drugs (MDMA/Ecstasy, Rohypnol/flunitrazepam, GHB)

CNS depressants (prescription tranquilizers and muscle relaxants)

Hallucinogens (LSD, Mescaline/peyote/cactus, Psilocybin/mushrooms)

Dissociative Drugs (Ketamine, PCP/phencyclidine/angel dust, Salvia plant species, dextromethorphan cough syrup)

Inhalants (solvents, glues, gases, nitrites/laughing gas)

10. With respect to SUD treatment in your county, what are the main barriers to access and engagement with treatment?

Transportation

Wait list to enter treatment

Language and/or cultural issues

Client not ready to commit fully to stopping use of drugs and/or alcohol

Failure to complete treatment program

Lack of treatment programs or options locally

Lack of workforce licensed/certified to treat clients who have co-occurring MH and SUD issues

Stigma and prejudice regarding diagnosis or participation in treatment

Reduced motivation of clients due to changes in court-required drug treatment programs (Proposition 47 reduced penalties for some substance use crimes, thus individuals may choose not to apply for drug court supervision of their case. Drug court is a way to reduce criminal penalties for some crimes in exchange for the client engaging in treatment for substance use).

Other, please describe Lack of Dual Diagnosis programs for clients with coexisting disorders, lack of support for clients in SUD treatment with low to moderate mental health issues including medication management for their needs. More mental health support could occur in SUD programs, especially residential facilities while the client is engaged in treatment via staff so that the after care plan of the client is a strong transition process into the community which should include linkages to the local mental health.

11. What could be done to increase successful outcomes for SUD recovery in your county? Choose the top three priorities.

Ongoing case management

Support individuals to make necessary changes in social patterns (new neighborhood; change routes to home, school or work; change circle of friends)

Medication services

Family treatment/education

Health and nutrition classes

Parenting classes

Onsite access or referrals for primary health care screening and treatment

Vocational training and support, including employment readiness classes

Other, please describe: Housing is the biggest pitfall for individuals who complete treatment, Sober Living Housing facilities should be available as well as “dry” shelter environments as clients transition back without a permanent housing option, this would preserve the gains made in treatment.

12. Have any SUD treatment strategies been shown to be especially successful in your county?

Yes None

If yes, please describe: Co-location of BH treatment, SBIRT Implementation in Primary Health Care Clinics, Buprenorphine Clinics for Pain Management patients and

safely treating opioid users, Ongoing Case Management of the Top 5% of high utilizers among AB109 SUD population

13. How does your county support individuals in recovery to increase the rates of success? Please check all that apply in your county.

- Transportation to outpatient treatment and therapy appointments
- Motivational interviewing
- Case management/aftercare/follow-up services and referrals
- Services more like FSP¹¹ or wrap-around services
- Family treatment and/or family education
- Medication services
- Teaching about activities of daily living
- Parenting classes
- Smoking cessation classes or treatment
- On-site health testing and treatment
- Linkage to primary care clinic for health tests and treatment
- Job readiness training, vocational services , GED/college classes
- Facilitate a change in the person's culture, to build new relationships, routines, patterns not linked to alcohol or drug use.
- Peer support, mentors or sponsors in the community
- Classes about nutrition, cooking, exercise, and care of one's own health
- Other, please describe _____

In your opinion, which of the above are the four factors most essential to client success in SUD recovery?

- ✓ Appropriate level of care placement: meeting the client where he/she is
- ✓ Client centered approach to treatment
- ✓ Complexity capable services:
- ✓ Integrated settings which allow clients to receive all services within the same roof

¹¹ Full Service Partnership mental health services, programs funded by the Mental Health Services Act.

- ✓ Strong after care support systems & linkages

14. **Prevention.** This last question is about coordinating prevention efforts between different agencies and groups. We believe that prevention and education activities are important to help reduce the number of persons using drugs or abusing alcohol, especially for youth under 18 and young adults.

The evidence shows that prevention efforts are much more effective when coordinated across multiple service systems. Currently, funding for MH efforts have a different source than that for substance abuse prevention¹² and therefore must be devoted to mental health. This results in most programs being separate or ‘siloe’d’ which risks producing fragmented, patchwork efforts and less than optimal outcomes for consumers.

Does your county implement coordinated programs to address prevention of both SUD and mental illness in children, transition-aged youth and young adults?

Yes X No _____

If yes, please provide a brief description of the program, target audience, and activities.

The First Hope Program, a MHSA funded Prevention & Early Intervention program of Contra Costa County Behavioral Health Services, provides early identification, assessment and intensive treatment services to young people, ages 12-25, and their families, who show signs and symptoms indicating they are at Clinical High Risk (CHR) for psychosis. As mentioned earlier in this Data Notebook, First Hope uses an evidence-based practice, the Portland Early Identification and Referral (PIER) Model, which has been effective in preventing conversion to psychosis and the subsequent disability associated with psychotic disorders. First Hope has a multi-disciplinary team that is composed of psychologists, mental health clinicians, psychiatrists, occupational therapists, and employment/education specialists.

The George and Cynthia Miller Wellness Center (Miller Wellness Center) is meant to serve several purposes in Contra Costa Behavioral Health Services’ system of care, including diverting children and adults from Psychiatric Emergency Services (PES). Through a close relationship with PES, the goal is also to allow children and adults who are evaluated at PES to quickly step-down to the Miller Wellness Center if they do not need hospital level of care. The Miller Wellness Center will offers urgent same-day appointments for individuals who are not open to the Contra Costa Mental Health System, or who have disconnected from care after previously being seen. Services will

¹² Examples of programs funded from different sources could include MHSA Prevention and Early Intervention programs or the substance Abuse Prevention and Treatment Block Grant. You may know of others in your community.

include brief family therapy, medication refills, substance abuse counseling, or general non-acute assistance. In addition, the Center is expected to have appointment slots for patients post psychiatric inpatient discharge. This will provide the opportunity to ensure a successful transition, make sure meds are obtained and appointments are scheduled in the home clinic. These appointment slots will be offered to patients being discharged from inpatient hospitals who have serious mental illness. Short term substance abuse counseling and referral for ongoing treatment for substance abuse will also be provided.

Drug and alcohol usage and the impact on the symptoms reported are given special attention during the assessments. Differential diagnosis and dual diagnosis are identified and addressed. Referrals are made to more intensive drug and alcohol programs if indicated. During the treatment phase psychoeducation with both clients and family members address the interplay of drug usage and symptoms that indicate clients are at Clinical High Risk (CHR) and increased risk for psychosis with continued usage. During the individual and family treatment, recovery approaches include risk reduction and abstinence models. Clients are also encouraged to attend AA, NA or other group resources.

The James Morehouse Project at El Cerrito High School, a MHSA funded Prevention & Early Intervention program of Contra Costa County Behavioral Health Services, is a student health center that partners with community based organizations, government agencies and local universities, provides a range of youth development groups designed to increase access to mental health services for at-risk high school students. These on-campus groups address coping with anger, violence and bereavement, factors leading to substance abuse, teen parenting and caretaking, peer conflict and immigration acculturation.

Also an MHSA funded program, La Clinica de la Raza reaches out to at-risk Latinos in Central and East County to provide behavioral health assessments and culturally appropriate early intervention services to address symptoms of mental illness brought about by trauma, domestic violence and substance abuse. Clinical staff also provide psycho-educational groups that address the stress factors that lead to serious mental illness.

Two MHSA PEI funded behaviorists (one with AOD specialty) have been hired at regional county health clinics to offer not only improved behavioral health services in each County clinic but also to help patients navigate appropriate external resources.

Addendum: Question #15

Resources for local Advisory Boards to carry out their Mandated Roles

These questions address the operations of county mental health boards, behavioral health boards, or mental health commissions, regardless of current title. These items have been included in partnership with the California Association of Local Mental Health Boards and Commissions.

(a) What process was used to complete this Data Notebook? Please check all that apply.

MH Board completed majority of the Data Notebook

County staff and/or Director completed majority of the Data Notebook

Data Notebook placed on Agenda and discussed at Board meeting

Other; please describe: Mental Health Administration answered questions 1—6 & 14; the MH Commission answered questions 7 & 8; Fatima MataSol, AOD Administration answered 9,10, 11,12, & 13; the Chair, of the MH Commission answered 15 and compiled the answers.

(b) Do you have suggestions for future Data Notebook themes or topics?

Yes No If yes, please list: Number of visits to Psych Emergency by those with a serious mental illness and outcomes; mental health programs & treatment in jails; housing for Behavioral Health and how to insure those with the most serious needs are met first.

(c) Does your Board have a yearly budget to support its activities?

Yes No If yes, \$ _____

(d) Does your Board have designated staff to support your activities?

Yes No

If yes, please provide their job classification –Contracted employee

Briefly describe their duties – The job title is Executive Assistant to the Mental Health Commission. The Service Activities of the contract says that the Contractor shall provide professional consultation and technical assistance to County’s Behavior Health Services Director with regard to the Mental Health Commission.

Contractor’s activities shall include, but are not limited to –technical assistance, consultation and coordination to the MH Commission to ensure their effective involvement in working with County’s Behavior Health Program Administration.

Attend monthly MHC and subcommittee meetings, as required by County; and other related duties as required by the County’s Behavioral Health Services Director.

What is the best method for contacting this staff member or board liaison?

Name and County: Karen Shuler, Contra Costa

Email: karen.shuler@hsd.cccounty.us

Phone # 925-957-5140

(e) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: Lauren Rettagliata, Contra Costa

Email: rettagliata@sbcglobal.net

Phone 925-683-3299

CALIFORNIA State Reference Data for SUD Treatment and Outcomes

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

Totals are for all counties.

Service Type:

Outpatient	DETOX	Residential	Total
89,071	19,904	24,763	133,738
66.60%	14.88%	18.52%	100%

Age at Admission:

Under 18	18 - 25	26 - 35	36 and Older	Total
14,957	23,614	38,042	57,125	133,738
11.18%	17.66%	28.45%	42.71%	100%

Gender:

Male	Female	Total
84,615	49,123	133,738
63.27%	36.73%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
1,612	2,984	16,926	49,352	5,070	57,794	133,738
1.21%	2.23%	12.66%	36.90%	3.79%	43.21%	100%

CALIFORNIA State Data, includes all counties.

CLIENT OUTCOMES: Key Indicators of Client Recovery for Prior 30 days at Discharge,

For Discharges in FY 2013-2014

Substance Use:

None	Use Data Missing	Use Documented	Total
28,093	29,016	9,553	66,662
42.14%	43.53%	14.33%	100.00%

Arrests:

1 or more Arrests	Arrest Data Missing	No Arrests	Total
1,160	29,016	36,486	66,662
1.74%	43.53%	54.73%	100.00%

Employment:

Employed	Data Missing	None	Total
10,596	29,016	27,050	66,662
15.90%	43.53%	40.58%	100.00%

Housing Situation

Homeless	Living Data Missing	Stable Housing	Total
3,167	29,016	34,479	66,662
4.75%	43.53%	51.72%	100.00%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Missing	Total
19,306	18,340	29,016	66,662
28.96%	27.51%	43.53%	100.00%

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

For information, you may contact the email address above, or telephone:

(916) 449-5249

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413

